Summary of Proposed Regulation Changes

KAR 129-5-88 re: Scope of physician services
Kansas Medicaid has opted to allow coverage for pancreas transplant for a Medicaid beneficiary when performed simultaneously or after a kidney transplant.

Pancreas transplants performed in conjunction with kidney transplants, for beneficiaries suffering from end stage renal disease and diabetes, can slow or even stop such complications as vision problems, heart disease, further renal disease. These complications can lead to blindness, lower limb amputation, multiple organ failure, and even death. These diabetic beneficiaries will also benefit from no longer having to receive multiple daily insulin injections and an overall better quality of life.

Studies have confirmed that simultaneous pancreas / kidney transplantation has a protective effect against cardiovascular mortality in diabetic recipients affected by end-stage renal disease.

Fiscal Impact
Costs are approximately $18,276 per transplant for pancreas after a kidney transplant and $28,854 for simultaneous pancreas / kidney transplant. Studies show that approximately 85-95 % of the pancreas transplants are performed simultaneously with kidney transplants. Currently, KHPA covers kidney transplants and the reimbursement cost on average would be the same for a kidney transplant as it is for a simultaneous pancreas / kidney transplant.

KHPA believes that the added costs of the transplants could be offset by a reduction in the complications that arise from diabetes and end stage renal disease, which can easily reach tens of thousands of dollars per year.

Public Comments and Expected Reaction
No public comments were received. This action is not considered controversial.

Approval Timeline
Date considered by Medicaid staff: August 31, 2006
Date published in Kansas Register: October 5, 2006
Date approved by KHPA executive staff: December 4, 2006

Summary of Proposed Regulation Changes

Summary: Replace regulatory language from SRS to KHPA

KAR 30-5-88 re: Scope of physician services
We would like to amend this regulation, which is currently housed in the SRS section of the K.A.R., but to accomplish this, the Secretary of State requires that we first revoke it and then replace it with a KHPA regulation (see proposed K.A.R. 129-5-88). Therefore, the staff proposes that KHPA revoke this regulation.

Fiscal Impact
It is anticipated there would be no fiscal impact.

Public Comment
No public comments were received.

129-5-88. Scope of physician services. (a) Except as specified in subsection (b), the program shall cover medically necessary services recognized under Kansas law provided to program recipients by physicians who are licensed to practice medicine and surgery in the jurisdiction in which the service is provided.

(b) The following services shall be excluded from coverage under the program:

(1) Visits. The following types of visits shall be excluded:

(A) Office visits when the only service provided is an injection or some other service for which a charge is not usually made;

(B) psychotherapy services when provided concurrently by the same provider with both targeted case management services and partial hospitalization services;

(C) psychotherapy services exceeding an average of 32 hours of individual therapy or 32 hours of group therapy or any combination of these in a calendar year for each recipient, unless the recipient is a Kan Be Healthy program participant and either of these conditions is met:

(i) Psychotherapy services do not exceed 40 hours in a calendar year for each Kan Be Healthy program participant; or

(ii) psychotherapy services are being rendered pursuant to a plan approved by the agency. The provider of psychotherapy services shall obtain prior authorization for the plan. The plan shall not exceed a two-year period and shall be subject to a reimbursement limit established by the agency. Quarterly progress reports shall be submitted to the division of medical programs;

(D) inpatient hospital visits in excess of those allowable days for which the hospital is paid or would be paid if there were no spend-down requirements; and

(E) nursing home visits in excess of one each month, unless the service provider documents medical necessity.

(2) Consultations. The following types of consultations shall be excluded:

(A) Consultations for which there is no written report;

(B) inpatient hospital consultations in excess of one for each condition in a 10-day period, unless written documentation confirming medical necessity is attached to the claim; and

(C) consultations in excess of one for each condition in a 60-day period, unless written documentation confirming medical necessity is attached to the claim.

(3) Surgical procedures. The following types of surgical procedures and services shall be excluded:

(A) Procedures that are experimental, pioneering, cosmetic, or designated as noncovered;

(B) all transplant surgery, except for the following:

(i) Liver transplants, which shall be performed only at a hospital designated by the agency, unless the medical staff of that hospital recommends another location; and

(ii) corneal, heart, kidney, pancreas, and bone marrow transplants and related services;

(C) the services of a surgical assistant if the surgeon determines that an assistant is not required for a particular surgery; and

(D) elective surgery, except for sterilization operations or for Kan Be Healthy beneficiaries.

(4) Miscellaneous procedures. The following types of miscellaneous procedures shall be excluded:

(A) Diagnostic radiological and laboratory services, unless the services are medically

necessary to diagnose or treat injury, illness, or disease;

(B) physical therapy, unless the following conditions are met:

(i) The therapy is performed by a physician or registered physical therapist under the direction of a physician; and

(ii) the therapy is prescribed by the attending physician;

(C) medical services of medical technicians, unless the technicians are under the direct supervision of a physician; and

(D) inpatient services that were provided on any day during a hospital stay and that are determined to not be medically necessary.

(5) Family planning services and materials.

(A) Family planning services and materials shall be excluded, unless all of the following conditions are met:

(i) The services are provided by a physician, family planning clinic, or county health department.

(ii) Written informed consent from the consumer is obtained as required by federal law and regulation.

(iii) The scope of services provided is in compliance with applicable federal and state statutes and regulations.

(B) Reverse sterilizations shall be excluded.

(6) Concurrent care shall be excluded, unless both of the following conditions are met:

(A) The patient has two or more diagnoses involving two or more systems.

(B) The special skills of two or more physicians are essential in rendering quality medical care. The occasional participation of two or more physicians in the performance of one procedure shall be recognized. Each physician involved shall submit that physician's usual charge for only that portion of the procedure for which the physician is actually responsible.

(7) Psychological services for an individual entitled to receive these services as a part of care or treatment from a facility already being reimbursed by the program or by a third-party payor shall be excluded.

(c) The services provided by mid-level practitioners, including advanced registered nurse practitioners and physician assistants, shall be covered. (Authorized by L. 2005, Ch. 187, § 45 and K.S.A. 2005 Supp. 75-7403; implementing L. 2005, Ch. 187, § 41; effective P-_____.)

30-5-88. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-9, April 11, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended, T-89-24, May 27, 1988; amended Sept. 26, 1988; amended, T-30-10-28-88, Oct. 28, 1988; amended Jan. 2, 1989; amended July 1, 1989; amended, T-30-7-29-89, July 29, 1989; amended Nov. 24, 1989; amended Aug. 1, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended July 1, 1996; amended July 1, 1998; revoked P-_____.)